Change

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I get it. Life has been rough in health care during the COVID-19 pandemic. No one needs to tell us there are a record number of health care clinicians struggling with burnout.[1] According to a recent poll, 30% of health care workers are considering leaving health care.[2] At my own institution as well as at others in our region, I have found our turnover rate to be shockingly high over the last year. With so many people leaving health care, there are significantly more responsibilities placed on those remaining to fight this pandemic.

So, what personally gives me hope in the midst of this chaos? Change. The kind of change we want, not the kind that is forced upon us. What kind of change do I want?

The recent report from the National Academies of Science, Engineering, and Medicine (NASEM) on rebuilding primary care, laid out five key strategies for us all to consider. For this column, I will focus on strategy number one: "Pay for primary care teams to deliver care for people, not doctors to deliver services."[3]

Given that one of my passions is to promote interprofessionalism, I was ecstatic to see this recommendation. Let's start at the beginning. "Pay" to me clearly means governments, health insurers, and private citizens need to change what they are paying for. Next, "primary care teams" to me means that we need more people in primary care doing more to ensure patients have what they need to stay healthy enough to have the highest quality of life possible, for as long as possible. "Deliver care for people," in my view, refers to ensuring that everyone is cared for in the context of their community, rather than within an exam room once a year. "Not doctors" is one of the most important phrases in this strategy because it implies that it takes a community to care for a community. Finally, "to deliver services," to me, refers to sickness care and procedures that never address the underlying health of our communities. To be clear, these are my interpretations of strategy number one, and I highly recommend reading the NASEM report in detail.

In conversations with my colleagues regarding the NASEM report, I heard concerns from some physicians that I have heard my entire career: other health care clinicians will replace physicians. It seems to me that any time I bring up broadening the scope of health care team members, a physician inevitably tells me a story of how they know of a group of physicians who were fired and were replaced with other types of clinicians. I always find that interesting because that is not what I see at all. Here I am, in the middle of a pandemic, watching our region struggle to find doctors, advance practice nurses, and physician assistants. We are struggling to find service representatives, medical assistants, and nurses. I am seeing the predicted physician shortage[4] occurring right now. I am not seeing anyone coming to take anyone's job; it's the absolute opposite: we need more people to meet the needs necessary to care for communities.

There is tremendous power in growing and grooming health care teams to care for patients and communities, and I wanted to share a personal example. In the family medicine clinic where I work, Fran Vlasses, PhD, RN, and Lisa Burkhart, PhD, RN, implemented a model of nurse-led care coordination teams where a registered nurse became each patient's interface with the family medicine care team. We used a concept we called "fluid leadership," where leadership of the patient's needs were transferred to the team member with the most knowledge and skills around each particular need. For example, as a physician, I would manage the patient's hypertension and

diabetes. A dietician would work with them on losing weight. A social worker would work with them on applying for electricity payment assistance. A psychologist would help them cope. For those patients with intensive medical needs such as out-of-control diabetes, they would see one of our advance practice nurses every week. I was so grateful for those weekly APRN visits because my schedule was too full to offer that type of service myself. On top of this very individualized approach was also layered the population health approach of working with our entire at-risk population for improved outcomes. One population approach was finding a partner to start a community garden to increase access to fruits and vegetables within our community. The results were what you would expect: significantly improved diabetes, hypertension, and obesity. The more surprising results were improved care-team morale and improved job satisfaction.[5] Fortunately, our experience is not unique. Many others have shown the benefits of the patent-centered medical home model and other team-based approaches.[6-8]

These newer interprofessional models of primary care are the change we need. The only way we will get to this change is to first change how the health care dollars are spent.

I am proud to be a part of the Society of Teachers of Family Medicine, as its members and administration have made it a welcoming and forward-thinking interprofessional organization. So, as we work to change how health care dollars are spent and direct them more toward the high-value solutions of primary care, I encourage all of us to fully embrace interprofessionalism. Not only is there room for everyone on the primary care team, but also there is a need for a lot more of everyone on the team!

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